

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016618

Facility Name: MID AMERICA CARE CENTER

Address: 4920 N. KENMORE AVE CHICAGO 60640
Number City Zip Code

County: COOK

Telephone Number: (773) 769-2700 Fax # (773) 769-3226

IDPA ID Number: 362688753001

Date of Initial License for Current Owners: 1975

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda Telephone Number: (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
Paid Preparer	(Title) _____	
	(Signed) See Accountants' Compilation Report Attached	
	(Date) _____	
	(Print Name and Title) CARY N. DRAZNER, C.P.A.	
	(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015	
(Telephone) (847) 236-1111 Fax# (847) 236-1155		
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number MID AMERICA CARE CENTER

0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	310	Skilled (SNF)	310	113,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	310	TOTALS	310	113,150	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	50,096		2,328	52,424	8
9	SNF/PED					9
10	ICF	37,036	355		37,391	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	87,132	355	2,328	89,815	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4. 79.38%)

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 1975

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 31 and days of care provided 2,328

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MID AMERICA CARE CENTER

0016618

Report Period Beginning: 01/01/01

Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	288,462	63,755	18,533	370,750		370,750		370,750			1
2	Food Purchase		449,611		449,611	(35,741)	413,870	(18)	413,853			2
3	Housekeeping	269,555	72,950		342,505		342,505	1,497	344,002			3
4	Laundry	101,525	17,901		119,426		119,426		119,426			4
5	Heat and Other Utilities			234,095	234,095		234,095	5,316	239,411			5
6	Maintenance	156,963	42,167	67,565	266,695		266,695	(5,006)	261,689			6
7	Other (specify): religious superv			200	200		200	58	258			7
8	TOTAL General Services	816,505	646,384	320,393	1,783,282	(35,741)	1,747,541	1,847	1,749,389			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	2,702,989	113,240	37,501	2,853,730		2,853,730	412	2,854,142			10
10a	Therapy	184,043		13,970	198,013		198,013		198,013			10a
11	Activities	172,121	18,285	234	190,640		190,640		190,640			11
12	Social Services	115,068		5,840	120,908		120,908		120,908			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,174,221	131,525	60,545	3,366,291		3,366,291	412	3,366,703			16
	C. General Administration											
17	Administrative	190,609		83,000	273,609		273,609	177,820	451,429			17
18	Directors Fees											18
19	Professional Services			686,531	686,531	(30,549)	655,982	(435,578)	220,404			19
20	Dues, Fees, Subscriptions & Promotions			79,451	79,451		79,451	(45,408)	34,043			20
21	Clerical & General Office Expenses	125,407	52,657	294,597	472,661		472,661	(99,776)	372,885			21
22	Employee Benefits & Payroll Taxes			675,595	675,595	35,741	711,336		711,336			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,324	1,324		1,324	1,229	2,553			24
25	Other Admin. Staff Transportation			1,892	1,892		1,892	(223)	1,669			25
26	Insurance-Prop.Liab.Malpractice			235,983	235,983		235,983	1,741	237,724			26
27	Other (specify):*							66,248	66,248			27
28	TOTAL General Administration	316,016	52,657	2,058,373	2,427,046	5,192	2,432,238	(333,947)	2,098,291			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,306,742	830,566	2,439,311	7,576,619	(30,549)	7,546,070	(331,688)	7,214,382			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			279,254	279,254		279,254	(21,832)	257,422			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,118	16,118		16,118	(16,118)	(0)			32
33	Real Estate Taxes			368,742	368,742	30,549	399,291	3,808	403,099			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,007	10,007		10,007	(4,794)	5,213			35
36	Other (specify):*											36
37	TOTAL Ownership			674,121	674,121	30,549	704,670	(38,936)	665,734			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportati											38
39	Ancillary Service Centers		92,055	202,335	294,390		294,390		294,390			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			169,725	169,725		169,725		169,725			42
43	Other (specify):*	111,831		1,525	113,356		113,356	(113,356)	0			43
44	TOTAL Special Cost Centers	111,831	92,055	373,585	577,471		577,471	(113,356)	464,115			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,418,573	922,621	3,487,017	8,828,211		8,828,211	(483,980)	8,344,231			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Numl MID AMERICA CARE CENTER

0016618

Report Period Beginning: 01/01/01

Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,989)	30		9
10	Interest and Other Investment Income	(21,827)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(48)	21		18
19	Entertainment				19
20	Contributions	(6,666)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(238,996)	21		24
25	Fund Raising, Advertising and Promotional	(33,279)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,878)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(157,405)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (505,105)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	21,125		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 21,125		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (483,980)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

ID#0016618

Report Period Beginning:01/01/01

Ending:12/31/01

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1 Capitalized Repairs & Maintenance	\$ (6,653)	06	1
2 MISCELLANEOUS INCOME	(5)	21	2
3 MARKETING CONSULTANT	(1,525)	43	3
4 MARKETING SALARIES	(111,831)	43	4
5 THEFT & LOSS	(4,591)	21	5
6 PP&ST OF IL UNCLAIMED CHECKS	(1,917)	21	6
7 PPA MISC EXP	(64)	21	7
8 COPE IL C.L.T.C. DUES	(6,537)	20	8
9 AUTO LEASE (335*12)	(4,028)	35	9
10 AUTO LEASE (253*11)	(2,786)	35	10
11 AUTO INSURANCE FOR NOT ALLOWED AUTO	(404)	25	11
12 AUTO LEASE MISC	(138)	35	12
13 ACCOUNTING (NON-ALLOWABLE)	(5,000)	19	13
14 RENTAL INCOME	(5,250)	06	14
15 GAIN ON SALE OF ASSETS	(128)	21	15
16 NON-CARE DEPRECIATION	(6,479)	30	16
17			17
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STATE OF ILLINOIS

Summary A

Facility Name & ID Numb MID AMERICA CARE CENTER# 0016618

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(18)											(18)	2
3	Housekeeping			1,497									1,497	3
4	Laundry													4
5	Heat and Other Utilities			2,435		2,881							5,316	5
6	Maintenance	(11,905)		5,618		1,281							(5,006)	6
7	Other (specify):*					58							58	7
8	TOTAL General Services	(11,923)		9,550		4,220							1,847	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			412									412	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Progr			412									412	16
	C. General Administration													
17	Administrative			116,496	60,220	1,104							177,820	17
18	Directors Fees													18
19	Professional Services	(5,000)		(432,313)	943	792							(435,578)	19
20	Fees, Subscriptions & Promotion	(46,482)		919	120	35							(45,408)	20
21	Clerical & General Office Expen	(262,693)		162,608	98	211							(99,776)	21
22	Employee Benefits & Payroll Tax													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,229									1,229	24
25	Other Admin. Staff Transportatio	(404)		181									(223)	25
26	Insurance-Prop.Liab.Malpractice			1,512		229							1,741	26
27	Other (specify):*			61,369	4,879								66,248	27
28	TOTAL General Administratio	(314,579)		(87,999)	66,260	2,371							(333,947)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(326,502)		(78,037)	66,260	6,591							(331,688)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MID AMERICA CARE CENTER# 0016618

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)
30	Depreciation	(36,468)		11,507	373	2,756							(21,832) 30
31	Amortization of Pre-Op. & Org.												31
32	Interest	(21,827)		585		5,124							(16,118) 32
33	Real Estate Taxes					3,808							3,808 33
34	Rent-Facility & Grounds			21,712		(21,712)							34
35	Rent-Equipment & Vehicles	(6,952)		2,158									(4,794) 35
36	Other (specify):*												36
37	TOTAL Ownership	(65,247)		35,962	373	(10,024)							(38,936) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation												38
39	Ancillary Service Centers												39
40	Barber and Beauty Shops												40
41	Coffee and Gift Shops												41
42	Provider Participation Fee												42
43	Other (specify):*	(113,356)											(113,356) 43
44	TOTAL Special Cost Centers	(113,356)											(113,356) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(505,105)		(42,075)	66,633	(3,433)							(483,980) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger		4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$				\$		1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			\$				\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **MID AMERICA CARE CENTER**

0016618

Report Period Beginni

01/01/01

Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	\$	MANAGCARE, INC.	100.00%	\$ 1,497	\$ 1,497	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	2,435	2,435	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	5,618	5,618	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	412	412	18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	111,219	111,219	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	3,287	3,287	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	919	919	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	162,608	162,608	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	1,229	1,229	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	181	181	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	1,512	1,512	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	61,369	61,369	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	11,507	11,507	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	585	585	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	21,712	21,712	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	2,158	2,158	30
31	V	19	HOME OFFICE	435,600	MANAGCARE, INC.	100.00%		(435,600)	31
32	V	17	ADMIN. SALARY - MOSHE DAVIS		MANAGCARE, INC.	100.00%	550	550	32
33	V	17	ADMIN. SALARY - JOSHUA DAVIS		MANAGCARE, INC.	100.00%	4,727	4,727	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 435,600			\$ 393,525	\$ * (42,075)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$	INTERCARE, LTD. C/O MANAGCARE	100.00%	\$ 143,220	\$ 143,220	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	943	943	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	120	120	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	98	98	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	4,879	4,879	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	373	373	20
21	V								21
22	V	17	MANAGEMENT FEES	83,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(83,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 83,000			\$ 149,633	\$ * 66,633	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	MAZEL MANAGEMENT	100.00%	\$ 2,881	\$ 2,881	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		1,281	1,281	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		58	58	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		1,104	1,104	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		792	792	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		35	35	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		211	211	21
22	V	26	INSURANCE		MAZEL MANAGEMENT		229	229	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT		2,756	2,756	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		5,124	5,124	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT		3,808	3,808	25
26	V	34	RENT	21,712	MAZEL MANAGEMENT			(21,712)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 21,712			\$ 18,279	\$ * (3,433)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **MID AMERICA CARE CENTER** # **0016618** Report Period Beginning: **01/01/01** Ending: **12/31/01**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	YOSEF DAVIS	President	Administrative	44.92%	SEE ATTACHED	33	55.00%	SALARY	\$ 15,000	17-1	1
2						SALARY ALLOCATED-INTERCARE			143,220	17-7	2
3	MOSHE DAVIS	Operations Dir.	Administrative	0.42%	SEE ATTACHED	3.2	8.00%	SALARY	11,019	17-1	3
4						SALARY ALLOCATED-MANAGCARE			550	17-7	4
5	JOSHUA DAVIS	Administrator	Administrative	0.42%	SEE ATTACHED	26.6	66.50%	SALARY	91,113	17-1	5
6						SALARY ALLOCATED-MANAGCARE			4,727	17-7	6
7	SHOSHANA BRAUN	Clerical	Clerical	0.42%	SEE ATTACHED	4.5	13.35%	SALARY	3,875	21-1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 269,504		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MID AMERICA CARE CENTER # 0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MID AMERICA CARE CENTER# 0016618Report Period Beginning: 01/01/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MANAGCARE, INC.Street Address 3553 W. PETERSON AVE -3RD FLRCity / State / Zip Code CHICAGO, IL. 60659Phone Number (773) 463-1313Fax Number (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOKEEPING INC.	1,010,160	4	\$ 3,472	\$	435,600	\$ 1,497	1
2	5	UTILITIES	BOOKEEPING INC.	1,010,160	4	5,647		435,600	2,435	2
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	1,010,160	4	13,027		435,600	5,618	3
4	10	NURSING SALARIES	BOOKEEPING INC.	1,010,160	4	956	956	435,600	412	4
5	17	ADMINISTRATIVE	BOOKEEPING INC.	1,010,160	4	257,918	257,918	435,600	111,219	5
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	1,010,160	4	7,622		435,600	3,287	6
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	1,010,160	4	2,131		435,600	919	7
8	21	CLERICAL AND GENERAL	BOOKEEPING INC.	1,010,160	4	377,089	309,593	435,600	162,608	8
9	24	SEMINARS	BOOKEEPING INC.	1,010,160	4	2,850		435,600	1,229	9
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	1,010,160	4	419		435,600	181	10
11	26	INSURANCE	BOOKEEPING INC.	1,010,160	4	3,506		435,600	1,512	11
12	27	GEN. ADMIN. EMP. BEN.	BOOKEEPING INC.	1,010,160	4	142,315		435,600	61,369	12
13	30	DEPRECIATION	BOOKEEPING INC.	1,010,160	4	26,685		435,600	11,507	13
14	32	INTEREST EXPENSE	BOOKEEPING INC.	1,010,160	4	1,357		435,600	585	14
15	34	RENT - BUILDING (RELAT)	BOOKEEPING INC.	1,010,160	4	50,350		435,600	21,712	15
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	1,010,160	4	5,005		435,600	2,158	16
17										17
18	17	ADMIN. SALARY - MOSHE	AVG HRS WORKED	40	4	6,985	6,985	3	550	18
19	17	ADMIN. SALARY - JOSHUA	AVG HRS WORKED	40	4	7,104	7,104	27	4,727	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 914,438	\$ 582,556		\$ 393,525	25

Facility Name & ID Number MID AMERICA CARE CENTER# 0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization INTERCARE, LTD. C/O MANAGCARE
 Street Address 3553 W. PETERSON AVE. 3RD FLOOR
 City / State / Zip Code CHICAGO, IL. 60659
 Phone Number (773) 463-1313
 Fax Number (773) 463- 5311

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	ADMINISTRATIVE	AVG. HOURS WORKED 60	6	\$ 260,400	\$ 260,400	33	\$ 143,220	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED 60	6	1,715		33	943	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED 60	6	218		33	120	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED 60	6	178		33	98	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED 60	6	8,871		33	4,879	5
6	30	DEPRECIATION	AVG. HOURS WORKED 60	6	678		33	373	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 272,060	\$ 260,400		\$ 149,633	25

Facility Name & ID Number MID AMERICA CARE CENTER

0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization MAZEL MANAGEMENT
Street Address 3553 W.PETERSON AVE.
City / State / Zip Code CHICAGO, IL. 60659
Phone Number (773) 463-1313
Fax Number (773) 463- 5311

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. BOOKPNG. INC	1,010,160	4	\$ 6,681	\$	435,600	\$ 2,881	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG. INC	1,010,160	4	2,971	1,747	435,600	1,281	2
3	7	EMPLOYEE BEN.-R&M SAL	MNGCR. BOOKPNG. INC	1,010,160	4	134		435,600	58	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG. INC	1,010,160	4	2,559		435,600	1,104	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG. INC	1,010,160	4	1,837		435,600	792	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. INC	1,010,160	4	82		435,600	35	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG. INC	1,010,160	4	489		435,600	211	7
8	26	INSURANCE	MNGCR. BOOKPNG. INC	1,010,160	4	531		435,600	229	8
9	30	DEPRECIATION	MNGCR. BOOKPNG. INC	1,010,160	4	6,392		435,600	2,756	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG. INC	1,010,160	4	11,883		435,600	5,124	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG. INC	1,010,160	4	8,830		435,600	3,808	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 42,389	\$ 1,747		\$ 18,279	25

Facility Name & ID Number MID AMERICA CARE CENTER # 0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MID AMERICA CARE CENTER

0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MID AMERICA CARE CENTER # 0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MID AMERICA CARE CENTER# 0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MID AMERICA CARE CENTER # 0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number MID AMERICA CARE CENTER # 0016618 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	MANUFACTURERS BANK		X	LINE OF CREDIT				350,000				16,118	6
7													7
8													8
9	TOTAL Facility Related						\$	350,000				\$ 16,118	9
	B. Non-Facility Related*												
10	See Supplemental Schedule											(16,118)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (16,118)	14
15	TOTALS (line 9+line14)						\$	350,000				\$ (0)	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1	INTEREST INCOME-M.M.		X				\$	\$			\$ (3,923)	1	
2	Allocated-Managcare	X									585	2	
3	Allocated-Mazel	X									5,124	3	
4	INTEREST INCOME		X								(2)	4	
5	INTEREST INCOME		X								(17,902)	5	
6												6	
7												7	
8												8	
9												9	
10												10	
11												11	
12												12	
13												13	
14												14	
15												15	
16												16	
17												17	
18												18	
19												19	
20												20	
21							\$	\$			\$ (16,118)	21	

Facility Name & ID Number **MID AMERICA CARE CENTER**

0016618 Report Period Beginning: **01/01/01** Ending: **12/31/01**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.			\$	382,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	372,550	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(9,450)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	382,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the court.)			\$	30,549	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND 77,208 For 1994-96 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	403,099	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1996	356,662	8	
		1997	366,600	9	
		1998	376,141	10	
		1999	373,617	11	
		2000	368,742	12	
REAL ESTATE TAX ACCRUAL 368742*1.04%=382,000					
ALLOCATED FROM MAZEL =\$3,808					
The refunds were not offset against the related expense since it was for Real Estate bills which were not used to calculate a reimbursement rate. The refund related to 1994, 1995, and 1996					
		FOR OHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2000	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates

RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 statement. The statement will not be

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

MID AMERICA CARE CENTER

COUNTY

COOK

FACILITY IDPH LICENSE NUMBE

0016618

CONTACT PERSON REGARDING THIS REI

Steve Lavenda

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the p cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion c home property which is vacant, rented to other organizations, or used for purposes other than long term care m entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	14-08-410-018-0000	4928 N KENMORE AVE	\$ 101,162.85	\$ 101,162.85
2.	14-08-410-019-0000	4922 N KENMORE AVE	\$ 101,162.85	\$ 101,162.85
3.	14-08-410-020-0000	4918 N KENMORE AVE	\$ 101,162.85	\$ 101,162.85
4.	14-08-410-021-0000	4912 N KENMORE AVE	\$ 61,324.89	\$ 61,324.89
5.	14-08-410-017-0000	4930 N KENMORE AVE	\$ 3,928.81	\$ 3,928.81
6.	SEE ATTACHED	SEE ATTACHED	\$ 40,914.95	\$ 4,045.61
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 409,657.20	\$ 372,787.86

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is nc used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing ho (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 ta is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:94,500

B. General Construction Type:ExteriorFrameNumber of Stories

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	94,500	1979	\$ 307,874	1
2					2
3	TOTALS	94,500		\$ 307,874	3

Facility Name & ID Number MID AMERICA CARE CENTER

0016618

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1979	1971	\$ 3,258,613	\$ 141,676	35	\$ 141,676	\$	\$ 3,258,613	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	2,575		20	-		2,575	9
10	Various			1979	33,995		20	-		33,995	10
11	Various			1980	13,673		20	-		13,673	11
12	Various			1981	107,932		20	4,205	(4,205)	90,419	12
13	Various			1982	4,750		20	-		4,750	13
14	Various			1983	1,787		20	-		1,787	14
15	Various			1984	25,291		20	395	395	24,231	15
16	Various			1985	17,828		20	925	925	16,162	16
17	Various			1986	62,698		20	3,223	3,223	53,232	17
18	Various			1987	18,422		20	501	501	13,522	18
19	Various			1988	33,825		20	1,353	1,353	18,567	19
20	Various			1989	23,916		20	1,201	1,201	16,938	20
21	Various			1990	23,550		20	1,178	1,178	13,559	21
22	Various			1991	20,020		20	1,478	1,478	7,747	22
23	Various			1992	51,260		20	2,563	2,563	24,093	23
24	Various			1993	7,134		20	357	357	3,280	24
25	Various			1994	32,273		20	1,613	1,613	11,724	25
26	Various			1995	227,831		20	11,547	11,547	75,136	26
27	Various			1996	136,732		20	6,837	6,837	38,093	27
28	Various			1997	26,804		20	1,340	1,340	6,082	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		115,064	6,024		4,923	(1,101)	71,432	68
69	Financial Statement Depreciation			39,193			(39,193)		69
70	TOTAL (lines 4 thru 69)		\$ 4,245,973	\$ 186,893		\$ 185,315	\$ (9,988)	\$ 3,799,610	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MID AMERICA CARE CENTER

0016618

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,245,973	\$ 186,893		\$ 185,315	\$ (1,578)	\$ 3,799,610	1
2	LINEN CHUTE	1998	2,494		20	125	125	490	2
3	DRAIN & VENTS	1998	6,485		20	324	324	1,296	3
4	WATER HEATER	1998	2,975		20	149	149	546	4
5	WATER TOWER	1998	13,150		20	658	658	2,413	5
6	SMOKE DAMPER	1998	7,100		20	355	355	1,331	6
7	PLASTER BOARD	1998	2,039		20	102	102	357	7
8	WATER TOWER	1998	1,721		20	86	86	315	8
9	ELEV DOOR DETECTORS	1998	3,975		20	199	199	763	9
10	HOT WATER TANKS	1998	12,300		20	615	615	2,050	10
11	LIFE SAFETY CODE IMP	1998	17,077		20	854	854	2,633	11
12	DOORS	1998	4,795		20	240	240	780	12
13	BLDG RENOV-LSC-AUD	1998	7,395		20	370	370	1,110	13
14	FIRE DAMPERS & DOORS	1999	7,348		20	367	367	979	14
15	GAS THERMOSTAT	1999	1,265		20	63	63	184	15
16	DAMPERS & FANS	1999	4,238		20	212	212	565	16
17	LIFE SAFETY CONSULT	1999	4,040		20	202	202	539	17
18	EXHAUST SYSTEM	1999	4,250		20	213	213	568	18
19	FIRE DAMPERS	1999	10,920		20	546	546	1,456	19
20	HALLWAY FIRE DOORS	1999	6,126		20	306	306	765	20
21	INSPECTION & REPORT	1999	1,400		20	70	70	187	21
22	GATE LOCKS	1999	2,774		20	139	139	382	22
23	WALLS & DOORS	1999	4,000		20	200	200	533	23
24	ASPHALT STRIPPING	1999	2,660		20	133	133	321	24
25	VENTILATOR & PIPING	1999	3,805		20	190	190	459	25
26	DINING ROOM OPENING	1999	3,584		20	179	179	403	26
27	SECURITY LINK	1999	15,000		20	750	750	1,750	27
28	ENTRY DOOR IMP.	1999	7,510		20	376	376	846	28
29	CCTV SYSTEM	1999	1,447		20	72	72	150	29
30	CCTV SYSTEM	1999	1,355		20	68	68	164	30
31	TELEPHONE SYSTEM	1999	697		20	35	35	85	31
32	CCTV SYSTEM	1999	892		20	45	45	109	32
33	ELECTRIC DOOR HOLDER	1999	748		20	37	37	86	33
34	TOTAL (lines 1 thru 33)		\$ 4,411,538	\$ 186,893		\$ 193,595	\$ 6,702	\$ 3,824,225	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MID AMERICA CARE CENTER

0016618

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,411,538	\$ 186,893		\$ 193,595	\$ 6,702	\$ 3,824,225	1
2	ELECTRIC DOOR HOLDER	1999	576		20	29	29	68	2
3	WALL MOUNTED MONITOR	1999	674		20	34	34	85	3
4	WANDERGARD SYSTEM	1999	500		20	25	25	63	4
5	WANDERGARD SYSTEM	1999	1,280		20	64	64	160	5
6	WANDERGARD SYSTEM	1999	674		20	34	34	85	6
7	CCTV	1999	479		20	24	24	60	7
8	WALL MOUNTED MONITOR	1999	437		20	22	22	55	8
9	NEW DRAIN PIPE	1999	625		20	31	31	80	9
10	CIRCUIT BREAKER BOX	1999	2,450		20	123	123	328	10
11	WANDERGARD VOICE PRC	1999	468		20	23	23	61	11
12	WANDERGARD CABLE	1999	790		20	40	40	107	12
13	VACUUM BREAKER	1999	1,200		20	60	60	155	13
14	LAMPS & CUBICLE CURT	1999	9,005		20	450	450	1,163	14
15	CARPET & LAMPS	1999	5,121		20	256	256	661	15
16	LAMPS & FIXTURES	1999	5,161		20	258	258	667	16
17	FIRE ALARM SYSTEM	2000	68,998		20	3,450	3,450	5,750	17
18	LNDY & KTCHN HTG SYS	2000	17,700		20	885	885	1,623	18
19	ELEVATOR GENERATOR	2000	3,374		20	337	337	365	19
20	IRON RAILING	2000	600		20	30	30	40	20
21	NSE STATION BUMPERS	2000	1,326		20	66	66	105	21
22	SPRINKLERS SYSTEM	2000	9,544		20	477	477	795	22
23	NSE STATION REMODEL	2000	124,573		20	6,229	6,229	9,863	23
24	FIRE PROOFING	2000	1,845		20	92	92	176	24
25	DRAINS & VENTS	2000	6,470		20	324	324	594	25
26	GO AMPERE	2000	9,800		20	490	490	898	26
27	WANDERGUARD	2000	6,180		20	309	309	372	27
28	CUBICLE CURTAINS	2000	4,171		20	209	209	418	28
29	THERAPY RM CABINETS	2000	1,400		20	70	70	140	29
30	CEILING TILE	2000	332		20	17	17	34	30
31	CERAMIC TILE	2000	1,267		20	63	63	126	31
32	NSE CAL SYSTEM	2000	6,887		20	344	344	631	32
33	ANNOUNCIATOR SYSTEM	2000	15,568		20	778	778	1,686	33
34	TOTAL (lines 1 thru 33)		\$ 4,721,013	\$ 186,893		\$ 209,238	\$ 22,345	\$ 3,851,639	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MID AMERICA CARE CENTER

0016618

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,721,013	\$ 186,893		\$ 209,238	\$ 22,345	\$ 3,851,639	1
2	TELEPHONE WIRING	2000	2,619		20	131	131	306	2
3	CARPETING & TRIM	2000	4,070		20	204	204	543	3
4	RUNNER MATS	2000	2,648		20	132	132	375	4
5	NEW CURCUITS	2000	13,300		20	665	665	1,441	5
6	WINDOW TREATMENT	2000	3,121		20	156	156	234	6
7	LOCK SYSTEM	2001	2,862		20	131	131	131	7
8	DOORS & LOCKS	2001	6,519		20	299	299	299	8
9	MONITOR	2001	1,875		20	71	71	71	9
10	MONITOR	2001	4,021		20	117	117	117	10
11	HUMIGUARD & TILE	2001	1,814		20	38	38	38	11
12	MONITOR	2001	1,931		20	40	40	40	12
13	MONITOR	2001	1,206		20	20	20	20	13
14	MONITOR	2001	1,695		20	28	28	28	14
15	MASONARY WORK	2001	2,600		20	33	33	33	15
16	TRANSMITTER	2001	1,073		20	14	14	14	16
17	WALL REPAIR	2001	6,800		20	57	57	57	17
18	DOOR OPERATOR	2001	4,606		20	211	211	211	18
19	STEEL SELECTOR TAPE	2001	2,113		20	27	27	27	19
20	ROOF REPAIR	2001	2,750		20	23	23	23	20
21	ELEC. CIR. & OUTLET	2001	2,845		20	12	12	12	21
22	PATIO AREA FENCE	2001	1,784		20	22	22	22	22
23	CCTV TO MONITORING	2001	2,812		20	141	141	141	23
24	MOTORS	2001	549		20	27	27	27	24
25	TURBINE PUMP	2001	2,943		20	147	147	147	25
26	ALARM/TRANSMITTER	2001	1,244		20	62	62	62	26
27	FIRE ALARM SYSTEM	2001	1,091		20	55	55	55	27
28	ASPHALT REPAIR	2001	2,740		20	137	137	137	28
29	PAINT	2001	1,456		20	73	73	73	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12H, Carried Forward		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 4,806,100	\$ 186,893		\$ 212,311	\$ 25,418	\$ 3,856,323	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MID AMERICA CARE CENTER

0016618

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1985		\$ 44,488	\$ 2,313	30	\$ 1,483	\$ (830)	\$ 24,098	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION-MANAGCARE			1997	5,186	463	20	519	56	2,291	9
10	ALLOCATION-MANAGCARE			1993	407	-	20	20	20	174	10
11	ALLOCATION-MANAGCARE			1988	635	20	20	31	11	422	11
12	ALLOCATION-MANAGCARE			1986	48,112	2,457	20	2,204	253	37,837	12
13											13
14											14
15	ALLOCATION-MAZEL			2001	934	11	20	23	12	23	15
16	ALLOCATION-MAZEL			2000	472	12	20	24	12	30	16
17	ALLOCATION-MAZEL			1998	1,664	57	20	83	26	308	17
18	ALLOCATION-MAZEL			1997	1,552	40	20	78	38	336	18
19	ALLOCATION-MAZEL			1996	1,058	18	20	53	35	295	19
20	ALLOCATION-MAZEL			1995	239	6	20	12	6	79	20
21	ALLOCATION-MAZEL			1994	945	17	20	47	30	305	21
22	ALLOCATION-MAZEL			1993	558	16	20	28	12	236	22
23	ALLOCATION-MAZEL			1991	418	13	20	20	7	204	23
24	ALLOCATION-MAZEL			1990	650	13	20	33	20	369	24
25	ALLOCATION-MAZEL			1989	406	9	20	17	8	214	25
26	ALLOCATION-MAZEL			1987	923	18	20	23	5	907	26
27	ALLOCATION-MAZEL			1986	3,729	194	20	184	(10)	3,003	27
28	ALLOCATION-MAZEL			1985	260	-	20	-		260	28
29											29
30	ALLOCATION-INTER CARE, LTD			2001	2,428	347	20	41	(306)	41	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 115,064	\$ 6,024		\$ 4,923	\$ (595)	\$ 71,432	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MID AMERICA CARE CENTER

0016618

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 462,270	\$ 77,560	\$ 42,402	\$ (35,158)	10	\$ 193,352	71
72	Current Year Purchases	22,548	19,922	921	(19,001)	10	921	72
73	Fully Depreciated Assets	660,458	26	26		10	660,366	73
74								74
75	TOTALS	\$ 1,145,276	\$ 97,508	\$ 43,349	\$ (54,159)		\$ 854,639	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocation -Managcare	1900	\$ 20,564	\$ 3,009	\$ 1,761	\$ (1,248)	5	\$ 14,038	76
77										77
78										78
79										79
80	TOTALS			\$ 20,564	\$ 3,009	\$ 1,761	\$ (1,248)		\$ 14,038	80

E. Summary of Care-Related Assets

		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,279,814	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 287,410	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 257,421	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,989)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,725,000	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1994 ALTIMA - 1994	\$ 17,799	\$ 589	\$ 17,799	86
87	4930 BLDG - 1998	159,035	5,890	22,578	87
88	4930 LAND - 1998	17,500			88
89					89
90					90
91	TOTALS	\$ 194,334	\$ 6,479	\$ 40,377	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

*** Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.**

**** This must agree with Schedule V line 30, column 8.**

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: 2,158 Description: ALLOCATED-MANAGCARE \$2,158

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1999 TOYOTA CAMR	\$ 278	\$ 3,056	17
18					18
19					19
20					20
21	TOTAL		\$ 278	\$ 3,056	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income yo facility received training aides from other faciliti

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

Facility Name & ID Number **MID AMERICA CARE CENTER**# **0016618** Report Period Beginning:**01/01/01** Ending:**12/31/01****XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 34,295	\$		\$ 34,295	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			14,446			14,446	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			46,530			46,530	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescripts			107,064			107,064	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						92,055		92,055	13
14	TOTAL			\$		\$ 202,335	\$ 92,055		\$ 294,390	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MID AMERICA CARE CENTER

0016618

Report Period Beginning: 01/01/01

Ending:

12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 91,147	\$	1
2	Cash-Patient Deposits	8,488		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,745,412		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	295,038		6
7	Other Prepaid Expenses	950		7
8	Accounts Receivable (owners or related parties)	3,603,089		8
9	Other(specify): See supplemental schedule	168,796		9
	TOTAL Current Assets			
10	(sum of lines 1 thru 9)	\$ 5,912,920	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	325,374		13
14	Buildings, at Historical Cost	3,417,648		14
15	Leasehold Improvements, at Historical Cost	1,224,359		15
16	Equipment, at Historical Cost	1,175,748		16
17	Accumulated Depreciation (book methods)	(4,737,946)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	500		23
	TOTAL Long-Term Assets			
24	(sum of lines 11 thru 23)	\$ 1,405,683	\$	24
	TOTAL ASSETS			
25	(sum of lines 10 and 24)	\$ 7,318,603	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 695,833	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,000		29
30	Accrued Salaries Payable	260,743		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	18,264		31
32	Accrued Real Estate Taxes(Sch.IX-B)	382,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	16,878		35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
	TOTAL Current Liabilities			
38	(sum of lines 26 thru 37)	\$ 1,723,718	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify)			
43	See supplemental schedule			43
44				44
	TOTAL Long-Term Liabilities			
45	(sum of lines 39 thru 44)	\$	\$	45
	TOTAL LIABILITIES			
46	(sum of lines 38 and 45)	\$ 1,723,718	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,594,885	\$	47
	TOTAL LIABILITIES AND EQUITY			
48	(sum of lines 46 and 47)	\$ 7,318,603	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,452,793	1
2	Restatements (describe):		2
3	Journal entry after cost report preparation SRT	(671)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines	\$ 5,452,122	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,102,763	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(960,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 142,763	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23	\$ 5,594,885	24 *

* This must agree with page 17, line 47.

Facility Name & ID Num MID AMERICA CARE CENTER

0016618

Report Period Beginning: 01/01/01

Ending:

12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,587,422	1
2	Discounts and Allowances for all Levels	(367,142)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,220,280	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	235,932	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 235,932	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	103,229	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	83,264	19
20	Radiology and X-Ray		20
21	Other Medical Services	48,543	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 235,036	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	154,603	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 154,603	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	85,123	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 85,123	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,930,974	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,783,282	31
32	Health Care	3,366,291	32
33	General Administration	2,427,046	33
	B. Capital Expense		
34	Ownership	674,121	34
	C. Ancillary Expense		
35	Special Cost Centers	407,746	35
36	Provider Participation Fee	169,725	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,828,211	40
41	Income before Income Taxes (line 30 minus line 40)**	1,102,763	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,102,763	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number MID AMERICA CARE CENTER

0016618

Report Period Beginning: 01/01/01

Ending:

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,864	2,152	\$ 78,697	\$ 36.57	1
2	Assistant Director of Nursing	3,032	3,336	80,510	24.13	2
3	Registered Nurses	36,393	38,414	893,341	23.26	3
4	Licensed Practical Nurses	26,178	27,847	442,776	15.90	4
5	Nurse Aides & Orderlies	114,186	121,416	1,105,590	9.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,334	12,438	184,043	14.80	8
9	Activity Director	1,992	2,240	42,461	18.96	9
10	Activity Assistants	15,558	16,682	129,660	7.77	10
11	Social Service Workers	10,709	11,365	115,068	10.12	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,508	30,240	288,462	9.54	15
16	Dishwashers					16
17	Maintenance Workers	11,619	13,469	156,963	11.65	17
18	Housekeepers	33,651	35,135	269,555	7.67	18
19	Laundry	11,355	12,225	101,525	8.30	19
20	Administrator	2,040	2,160	86,523	40.06	20
21	Assistant Administrator	624	720	22,661	31.47	21
22	Other Administrative	2,355	2,355	81,425	34.58	22
23	Office Manager					23
24	Clerical	10,624	11,530	125,407	10.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,159	9,702	102,075	10.52	31
32	Other Health Care(specify)					32
33	Other(specify)	4,321	4,679	111,831	23.90	33
34	TOTAL (lines 1 - 33)	335,501	358,103	\$ 4,418,573 *	\$ 12.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	437	\$ 18,533	01-03	35
36	Medical Director	monthly	3,000	09-03	36
37	Medical Records Consultant	96	4,032	10-03	37
38	Nurse Consultant	784	31,620	10-03	38
39	Pharmacist Consultant	monthly	1,800	10-03	39
40	Physical Therapy Consultant	116	6,311	10a-03	40
41	Occupational Therapy Consultant	68	3,606	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	12	234	11-03	44
45	Social Service Consultant	108	5,840	12-03	45
46	Other(specify)				46
47	REHAB CONSULTANT	86	4,053	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	1,707	\$ 79,029		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 49	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$ 49		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name	Function	Ownership %	Amount	Description		Amount		Description		Amount					
			\$	Workers' Compensation Insurance		\$	54,457	IDPH License Fee		\$					
SEE ATTACHED			109,184	Unemployment Compensation Insurance			30,652	Advertising: Employee Recruitment			17,179				
SEE ATTACHED			81,425	FICA Taxes			332,300	Health Care Worker Background Check							
				Employee Health Insurance			188,488	(Indicate # of checks perform_ 109)			767				
				Employee Meals			35,741	LICENSE & PERMITS			3,359				
				Illinois Municipal Retirement Fund (IMRF)*				DUES & SUBSCRIPTIONS			11,664				
				CHICAGO HEAD TAX			8,044	Fees-allocation Managcare			919				
				HOLIDAY EXPENSE			4,492	Fees-allocation Mazel			35				
				EMPLOYEE DISABILITY INSURANCE			5,901	Fees-allocation Inter Care			120				
				EMPLOYEE PENSION/UNION			51,261								
								Less: Public Relations Expense							
								Non-allowable advertising							
								Yellow page advertising							
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$	190,609		TOTAL (agree to Schedule V, line 22, col.8)		\$	711,337		TOTAL (agree to Sch. V, line 20, col. 8)		\$	34,042	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**							
Description		Amount		Description		Line #	Amount	Description		Amount					
MANAGEMENT FEES-INTERCARE		\$	83,000				\$	Out-of-State Travel		\$					
								In-State Travel							
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	83,000											
C. Professional Services				<th colspan="2"><th colspan="2"><th colspan="2"></th></th></th>		<th colspan="2"><th colspan="2"></th></th>		<th colspan="2"></th>							
Vendor/Payee	Type	Amount		<th colspan="2"><th colspan="2"><th colspan="2"></th></th></th>		<th colspan="2"><th colspan="2"></th></th>		<th colspan="2"></th>							
MANAGECARE	BOOKKEEPING	\$	435,600												
COMMITMENT CONSULTING	MANAG CONSULTING		141,621												
PERSONNEL PLANNERS	Unemployment Consultant		2,236												
FR&R	ACCOUNTING		64,037												
SEE ATTACHED	LEGAL		32,945												
ECONOCARE	PURCHASING		5,220												
JCAHO CONSULTANTS	Joint Commission Conslt		2,400					Seminar Expense			1,324				
AMERICAN EXPRESS	Compliance Consultant		2,472					Allocation-Managcare			1,229				
								Entertainment Expense							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$	686,531		TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$	2,553			

*** Attach copy of IMRF notifications**

****See instructions.**

Mid-America Convalescent Center, Inc.
16618
1/1/01-12/31/01
Attachment to Page 21

A. Administrative Salaries

			%	
			<u>Ownership</u>	<u>Salary</u>
Yehoshua Davis	(1/1/01-4/9/01)	Administrator	0.42%	\$36,923
Michael Appelbaum	(4/10/01-12/31/01)	Administrator	0	49,600
Michael Appelbaum	(1/1/01-4/9/01)	Asst. Admin.	0	22,661
				<u>\$109,184</u>

A. Administrative - Other Salaries

Yosef Davis	Director	44.92%	\$15,341
Eli Tropper	Administrative Consultant	0	875
Moshe Davis	Director	0.42%	11,019
Yehoshua Davis	Director	0.42%	54,190
			<u>\$81,425</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number: MID AMERICA CARE CENTER

0016618

Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount: IL COUNCIL ON LONG TERM CARE \$11,664
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. 19,172 Line 10-02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 169,725
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 35,741 Has any meal income been offset against related costs? NO Indicate the amount \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such program during this reporting period. N/A
c. What percent of all travel expense relates to transportation of nurses and personnel? NONE
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accountant? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees